Commonwealth of Massachusetts
Health Insurance Responsibility Disclosure (HIRD) Form
For HR/CMS and UMASS Agencies

Agency: Please complete the first section of this form and give it to every employee in your agency who does not enroll in GIC or Connector Authority health coverage.

SECTION I

Agency:_____ Federal Employer Identification Number (FEIN): 046002284

Address, City, State, Zip:_____

Payroll Coordinator Name:_____Telephone number:_____

For GIC-eligible employees, enter the lowest available monthly employee share of GIC health insurance individual coverage premium: 15% $_____ 20% $ _____

The Agency must retain this form for three (3) years and make it available to the Division of Health Care Finance and Policy and the Department of Revenue upon request as required by 114.5 CMR 18.00. ***DO NOT SEND THIS FORM TO THE GIC OR THE CONNECTOR***. If the employee does not return a signed, completed form, you must document efforts to obtain it.

Employee is *(check one):* GIC eligible ☐ Connector Authority eligible ☐

Employee: You must complete and sign this form because you do not appear to have health insurance.

SECTION II

Name *(please print)*: _____
First Middle Initial Last

Social Security Number:_____

Please check the appropriate box for each question:

1) Were you offered Commonwealth-subsidized (GIC) health insurance? Yes ☐ No ☐

   1a) If yes, did you decline the Commonwealth-subsidized (GIC) health insurance? Yes ☐ No ☐

2) Were you offered the Section 125 Cafeteria Plan to pay for health insurance (the opportunity to pay for health insurance on a pre-tax basis through the GIC or the Connector Authority)? Yes ☐ No ☐

   2a) If yes, did you decline to use the Section 125 Cafeteria Plan? Yes ☐ No ☐

3) Do you have other health insurance (non-GIC)? Yes ☐ No ☐

4) Do you have health insurance through the GIC as an employee of another agency or spouse/dependent of a state employee? Yes ☐ No ☐

I hereby affirm under the penalties of perjury that all of the information provided herein is true to the best of my knowledge. I also understand that if I do not have health insurance, I may be responsible for the full cost of all medical treatment, and that I may forfeit all or a portion of my Massachusetts personal tax exemption and be subject to other penalties pursuant to Mass. General Laws chapter 111M. I also understand that this HIRD form contains information that must be reported in my Massachusetts tax return, and that I am required to maintain a copy of the signed form.

Signature: _____ Date (MM/DD/YY):_____

RETURN COMPLETED FORM TO YOUR PAYROLL DEPARTMENT AT THE ADDRESS ABOVE
DO NOT RETURN TO THE GIC OR THE CONNECTOR AUTHORITY